MARKET CONDUCT EXAMINATION REPORT
Dated May 15, 2013

COVERING THE TIME PERIOD OF JULY 01, 2011 THROUGH JUNE 30, 2012

DENVER HEALTH MEDICAL PLAN, INC.
777 Bannock Street
Denver, Colorado 80204

NAIC Company Code: 95750

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

DENVER HEALTH MEDICAL PLAN, INC.

MARKET CONDUCTEXAMINATION REPORT
Dated May 15, 2013

COVERING THE TIME PERIOD OF JULY 01, 2011 THROUGH JUNE 30, 2012

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC
Examiner-in-Charge

David M. Tucker, FLMI, ACS, AIE

And

Violetta R. Pinkerton, CIE, MCM, CPCU

SECTION **PAGE**

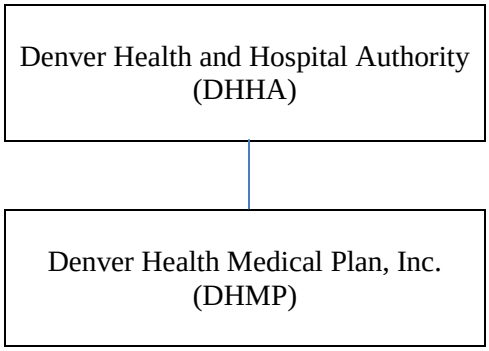
The following profile is based on information provided by Denver Health Medical Plan, Inc. and has not been verified by the Colorado Division of Insurance:

The Denver Health Medical Plan, Inc. (DHMP), licensed and operating as of 1/2/1997, was created to fill a need for affordable health care coverage for employees of the Denver Health Authority and the Career Service Authority. DHMP is an entity of the Denver Health and Hospital Authority (DHHA).

DHMP is a non-profit organization and operated for promotion of social welfare within Section 501(c)4 of the IRS code. The plan operates in the State of Colorado in the counties of Adams, Arapahoe, Denver and Jefferson.

Denver Health Medical Plan, Inc. is an independent entity with no affiliates or subsidiaries.

The following flow chart represents the organization structure of the Company:



Premium and Market Share as of December 31, 2011:

Total Written Premium:	$ 96,318,000.00*
Market Share (As a percentage of Colorado Total Accident and Health):	0.94%*

* As shown in the 2011 Edition of the Colorado Insurance Industry Statistical Report

State market conduct examiners with the Colorado Division of Insurance ("Division") reviewed certain business practices of Denver Health Medical Plan, Inc. ("Denver Health" or "Company"). The market conduct examination ("MCE") was performed in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, 10-1-205, 10-3-1106 and 10-16-416, C.R.S., that empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in the State of Colorado. All work product developed in the course of conducting this examination is the sole property of the Division.

The purpose of the examination was to determine Denver Health's compliance with Colorado insurance laws related to health benefit plans written in Colorado. Examination information contained in this report should serve only this purpose, except as provided in law pursuant to §§ 10-1-204 and 10-1-205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be a public record.

Examiners conducted the examination in accordance with procedures developed by the Division which are based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). They relied primarily on records and materials maintained and/or supplied by Denver Health. This MCE covered the period from July 1, 2011, through June 30, 2012.

The examination included review of claims, utilization review ("UR") and the Company's operations and management practices.

The examination report is a report by exception. References to additional practices, procedures, or files that did not contain improprieties or that did not exceed the error tolerance levels established by the NAIC were omitted. Based on review of these areas, comment forms were prepared for Denver Health identifying any concerns and/or discrepancies. The comment forms contained a section that permitted the Company to submit written responses to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Denver Health practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company, Health Maintenance Organization (HMO) or product.

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examiners reviewed all relevant statutes and regulations pertaining to health benefit plans offered or marketed by a health maintenance organization.

Sampling Methodology

The examiners selected all files where a sample of a larger population was taken, on a random sample basis as outlined in the sampling methodology in the 2012 NAIC Market Regulation Handbook ("Handbook").

An error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established per the Handbook to determine reportable exceptions.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance was applied to identify possible system errors.

Company Operations and Management

The examiners reviewed Denver Health's complaint records, documentation of its network adequacy and monitoring procedures, corporate guidelines, procedures and practices, and the Company's cooperation with the examination process for compliance with Colorado insurance law.

Claims Handling

The examiners reviewed claims samples, derived from the population of 42,966 claims the Company received during the examination period for compliance with statutory requirements and contractual obligations.

Two samples were reviewed for overall claim handling and accuracy of processing:

- One hundred (100) paid claims from a population of 38,972; and
- One hundred (100) denied claims from a population of 3,994.

Three samples were reviewed to determine Denver Health's compliance with Colorado's prompt payment of claims laws:

- One hundred (100) electronic claims from a population of 2,104 electronic claims adjudicated more than thirty (30) days after receipt of the claims;
- One hundred (100) nonelectronic claims from a population of 157 nonelectronic claims adjudicated more than forty-five (45) days after receipt of the claims; and
- The entire population of fifty-eight (58) electronic and nonelectronic claims received during the examination period adjudicated more than ninety (90) days after receipt of the claims.

Utilization Review

The examiners reviewed Denver Health's utilization review ("UR") program including policies and procedures for compliance with Colorado insurance law. The examiners reviewed the following UR samples for compliance with statutory requirements:

- One hundred (100) UR approval files from a population of 1,445;
- The entire population of forty-nine (49) UR declination files; and
- The entire population of ten (10) first level UR appeal files.

The Company stated that it did not have any second level appeals or independent external reviews during the examination period.

Prior Examinations

The Company's most recent market conduct examination by the Division prior to this examination covered the period of January 1, 2006 through December 31, 2006. That examination resulted in a Final Agency Order being issued on July 29, 2008.

The examination resulted in a total of nine (9) findings in which the Company was not in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Company Operations and Management: In the area of the Company operations and management, the examiners identified one (1) area of concern:

Issue A1: Failure, in some instances, to maintain and provide all documentation required for a market conduct examination.

Claims Handling: In the area of claims handling, the examiners identified four (4) areas of concern:

Issue J1: Failure, in some instances, to allow the required time period for submission of needed additional information prior to denial of an unclean claim. *(This is a repeat of issue J3 in the market conduct examination report as of December 31, 2006, signed August 28, 2008.)*

Issue J2: Failure, in some instances, to correctly determine and assign the received dates of claims.

Issue J3: Failure, in some instances, to pay, deny or settle claims within the required time periods.

Issue J4: Failure, in some instances, to pay interest and penalty when owed, in accordance with Colorado insurance law.

Utilization Review: In the area of UR, the examiners identified four (4) areas of concern:

Issue K1: Failure, in some instances, to make timely notification to covered persons of first level utilization review appeal determinations.

Issue K2: Failure to provide the name, title and qualifying credentials of the reviewer or clinical peer in first level utilization review determination notifications to covered persons.

Issue K3: Failure, in some instances, to provide a reference to the evidence or documentation used as the basis for an adverse first level utilization review determination in its notification to covered persons.

Issue K4: Failure, in some instances, to inform covered persons of their right to request and receive relevant information upon issuance of an adverse first level utilization review determination.

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some instances, to maintain and provide all documentation required for a market conduct examination.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

> . . .
>
> Section 4. Records Required For Market Conduct Purposes
>
> A. Every entity subject to the Market Conduct process shall *maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations*, including but not limited to, company operations and management, policyholder services, claims practices, rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, *utilization review*, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years.
>
> . . .
>
> Section 12. Records Usually Required For Examination
>
> A. Records required for examination usually include, but are not limited to, the following, depending on the line of business;
>
> . . .
>
> I. *Utilization review:* utilization review plan, utilization review policies and procedures, annual utilization review certifications, utilization review monthly telephone reports, *precertification records*, nurse's notes, medical director reviews and appeals of noncertification records; [Emphases added.]

During the review of the sample of 100 UR decisions rendered by Denver Health during the examination period, the Company was unable to provide the following records relating the Company's UR process:

- Fourteen (14) UR approval notification letters that were to be provided to the members.

As such, the Company's compliance with Colorado insurance law as it pertains to its utilization policies and procedures could not be fully tested.

Recommendation No. 1:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 1-1-7 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that it retains all documentation required for market conduct examinations as required by Colorado insurance law.

CLAIMS HANDLING

Issue J1: Failure, in some instances, to allow the required time period for submission of needed additional information prior to denial of an unclean claim. *(This is a repeat of issue J3 in the market conduct examination report as of December 31, 2006, signed August 28, 2008.)*

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(4)(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claims shall be paid, denied or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

Using ACL™ software, the examiners identified a population of 3,994 claims denied during the examination period. The examiners randomly selected a sample of 100 claims from that population for review.

Denver Health was not in compliance with Colorado insurance law in that it denied eight (8) of the claims at the same time it notified the provider that additional information was needed to determine liability for the claim. Denver Health denied the claims without waiting the required thirty (30) calendar days for the additional information to be submitted. In addition, the Company explained to the examiners that it has a business practice of denying any claim needing additional information and does not pend claims to wait for additional information to be submitted.

PREMATURELY DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Error Rate
3,994*	100	8	8%

(*9.3% of all claims received)

When Denver Health denied a claim it issued a remittance advice to the provider, which included the following statement on the back of the last page: “If a claim has been pended or denied for lack of proper coding or other additional information needed to comprise a clean and complete claim, a provider may resubmit the corrected claim with the necessary information to have it reconsidered for adjudication purposes. Colorado Revised Statutes § 10-16-106.5 (4)(b) states that providers receiving a request for additional information shall submit all additional information requested within 30 calendar days after receipt of such a request.” However, claims were not kept open when additional information was requested and if the claim was resubmitted with the needed information, the Company didn’t process that information on the original claim. Instead, the Company opened a new claim, assigned a new claim number, and processed the resubmitted claim as a new claim.

Colorado insurance law provides that a carrier may deny a claim for which information needed and requested is not provided within thirty (30) days after it was requested. When a carrier receives an unclean claim, it must request the information it needs to determine its liability within thirty (30) days of receiving the claim. A carrier is not in compliance with Colorado insurance law if it does not allow thirty (30) days from the date of its request for the needed information to be provided before denying the claim.

Recommendation No. 2:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its claims processing procedures and practices to ensure that it pends (holds in an open status) unclean claims when it requests additional information. Further, Denver Health shall provide written evidence that unclean claims are no longer being denied until the Company has allowed at least thirty (30) calendar days after it pends (holds in open status) a claim and sends a request for additional information for the appropriate party to submit the additional information as required by Colorado insurance law. In addition, the Company shall provide written evidence that it will consistently include a complete explanation in writing or a copy of the "Pended Reason Codes" document with each remittance advice for a pended claim and with each explanation of benefits to members with a pended claim.

In the market conduct examination for the period of January 1, 2006, through December 31, 2006, Denver Health was cited for failure to allow the required time period for submission of required information prior to denial of a claim. The violation resulted in Item #11 of Final Agency Order O-09-004. The Commissioner directed the Company to revise its procedures "to ensure that any information required to resolve a claim is requested within thirty (30) calendar days after receipt of the claim, and the person from whom the information is requested is given thirty (30) calendar days to provide the information as required by Colorado insurance law". Failure to comply with the previous order of the Commissioner constitutes a willful violation of § 10-1-205, C.R.S.

Issue J2: Failure, in some instances, to correctly determine and assign the received dates of claims.

Section 10-16-106.5, C.R.S, Prompt payment of claims – legislative declaration, states in part:

. . .

(2.7)(b)(I) *A carrier shall make a mechanism available to providers that shall enable a provider to confirm the receipt of a claim that is filed with the carrier in a manner other than electronically. Within ten business days after the submission of the claim as determined by the provider, the carrier shall list such claim on the notification mechanism as received. The claim shall be deemed received on the date it is listed on the notification mechanism by the carrier.* If a claim is not listed on the notification mechanism, the provider may contact the carrier for the purposes of resubmission of the claim. The carrier shall have a separate facsimile process to receive the resubmission of the paper claims. *The resubmitted claim shall be deemed received on the date of the facsimile transmission acknowledgment.* If such mechanism is accessible only by electronic means, upon request of the provider, the information must be made available in hard-copy form within three business days.

(II) *If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the carrier or the carrier's clearinghouse.* The carrier or carrier's clearinghouse shall provide a confirmation within one business day after submission by a provider.

. . .

(4)(a) Clean claims shall be paid, denied, or settled *within thirty calendar days after receipt* by the carrier if submitted electronically and *within forty-five calendar days after receipt* by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, *within thirty calendar days after receipt of the claim*, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, *the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).*

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled *within ninety calendar days after receipt* by the carrier. [Emphases added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states, in part:

. . .

Section 6. Additional Information

A. A claim with all required fields is not considered "clean" if additional information is needed in order to adjudicate the claim. Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. When additional information is required the carrier shall make the specific request in writing *within thirty calendar days after receipt of the claim form.* If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. The specific information requested shall be requested *within 30 calendars days after receipt of the claim form* and identified for the provider upon request. [Emphases added.]

Using ACL™ software, the examiners identified a population of 42,966 claims received during the examination period. The examiners further identified a population of 40,412 electronic claims and a population of 2,554 non-electronic claims received during the examination period.

Denver Health was not in compliance with Colorado insurance law in that in some instances, it assigned incorrect received dates to its claims. The Company subsequently used these incorrect received dates to determine the timeliness of claims payments and denials. The incorrect assignment of the received date of a claim resulted in the incorrect determination of the number of days after receipt to pay or deny a claim. In addition, the incorrect determination of the number of days to process a claim caused the incorrect determination of the amount, if any, of interest and penalty that was owed due to late adjudication.

Denver Health contracted with Cofinity to utilize its network of providers for its Point of Service (POS) plan. As part of that contractual arrangement, Cofinity also acted as a repricer for Denver Health POS claims. Cofinity received claims, repriced the claims, and forwarded the claims via electronic data feed to Denver Health's claims system. The member identification (ID) cards for both the Company's POS and HMO benefit plans listed only Cofinity's address as the mailing address where claims were to be submitted. This indicated that Cofinity also acted as a clearinghouse for claims, receiving Denver Health's claims and repricing each claim from a network provider or noting as such any that were not from a Cofinity network provider. In either case, Cofinity uploaded the claims to Denver Health's system via an electronic data feed. Cofinity was therefore acting as a clearinghouse for all Denver Health claims, whether submitted by a Cofinity network provider or a provider who was not a member of the Cofinity network.

During the review of various randomly selected claims samples, the examiners noted a discrepancy in the received dates assigned to claims. The repricing sheets and other notifications Cofinity completed for

Denver Health included a Cofinity claim number and the date Cofinity processed the claim, either repricing the claim or noting the claim was from a non-network provider. Both Cofinity and Denver Health assigned a claim number that contained within it the date each entity received it. Under Colorado insurance law, claims are considered received on the earliest date they are received by either the carrier or its clearinghouse. Denver Health assigned the date it received a claim from its clearinghouse as the received date of a claim, instead of assigning the date the claim was received by the clearinghouse if it was earlier.

Recommendation No. 3:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., and Colorado Insurance Regulation 4-2-24 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its claims processing procedures to ensure that all claims, whether received directly by the Company itself or through the Company's clearinghouse, are assigned the correct date of receipt as required by Colorado insurance law.

In addition, in conjunction with Recommendation #5, Denver Health shall conduct a self-audit of all claims received July 1, 2011, through June 30, 2012 to calculate the number of claims for which interest or penalty was owed but not paid or was paid incorrectly. Denver Health shall pay the member or provider any interest or penalty which was owed or incorrectly calculated as a result of its use of incorrect dates of receipt. A report of the self-audit shall be provided to the Division no later than ninety (90) days from the date this report is adopted.

Issue J3: Failure, in some instances, to pay, deny or settle claims within the required time periods.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents*. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*

. . .

(c) Absent fraud, *all claims* except those described in paragraph (a) of this subsection (4) *shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period, there were 40,412 claims received electronically. The examiners identified 2,104 claims from the population of electronic claims as not having been paid, denied or settled within thirty (30) calendar days from date of receipt.

Of these 2,104 claims, the examiners extracted a random sample of 100 claims using ACL ™ software. Denver Health was not in compliance with Colorado insurance law in that all 100 claims in the sample were clean claims that were not paid, denied or settled within thirty (30) days from receipt as required for clean electronic claims.

ELECTRONIC CLAIMS ADJUDICATED MORE THAN 30 DAYS AFTER RECEIPT

Population	Sample Size	Number of Clean Claims	Number of Exceptions	Error Rate
2104*	100	100	100	100%

{*5.21% of all electronic claims received}

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period, there were 2,554 paid and denied claims received in paper format. The examiners identified 157 paper claims from this population as not having been paid, denied or settled within forty-five (45) calendar days from date of receipt.

Of these 157 claims, the examiners extracted a random sample of 100 claims using ACL ™ software. Denver Health was not in compliance with Colorado insurance law in that all 100 claims in the sample were clean claims that were not paid, denied or settled within forty-five (45) days from receipt as required for clean non-electronic claims.

NON-ELECTRONIC CLAIMS ADJUDICATED MORE THAN 45 DAYS AFTER RECEIPT

Population	Sample Size	Number of Clean Claims	Number of Exceptions	Error Rate
157*	100	100	100	100%

{*6.14% of all non-electronic claims received}

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period, there was a total population of fifty-eight (58) claims paid, denied or settled in excess of ninety (90) calendar days during the examination period.

The entire population of fifty-eight (58) claims was selected for review. No evidence of fraud was found in any of the files reviewed. The Company was not in compliance with Colorado insurance law in that all fifty-eight claims in the sample were not paid, denied or settled within ninety (90) days of receipt as required for claims not involving fraud.

CLAIMS ADJUDICATED MORE THAN 90 DAYS AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Error Rate
58*	58	58	100%

{*0.135% of all claims received}

Recommendation No. 4:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its claims processing procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J4: Failure, in some instances, to pay interest and penalty when owed, in accordance with Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(4) (a) *Clean claims shall be paid, denied, or settled* within thirty calendar days after receipt by the carrier if submitted electronically and *within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b),* subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claims shall be paid, denied or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

. . .

(5) (a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, *shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim,* accruing from the date payment was due pursuant to subsection (4) of this section.

(b) *A carrier* that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim *shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim.* Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee.

(c) To the extent that penalties are not paid concurrently with the claim, *the penalties in this section may be paid on a quarterly* basis or when the aggregate penalties for a provider exceeds ten dollars. [Emphases added.]

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period, there were 40,412 claims received electronically.

Using ACL™ software, the examiners identified a population of 2,104 electronically submitted claims paid, denied or settled in excess of thirty (30) days during the period under examination. A random sample of 100 such claims was selected for review.

Upon review of the sample, the examiners determined that an interest payment was due in eighty-one (81) of the 100 electronic claims reviewed. The Company was not in compliance with Colorado insurance law in that it failed to pay interest at a rate of ten percent (10%) annually of the total amount ultimately allowed on the claim to the insured or health care provider in forty-two (42) of the eighty-one (81) clean electronic claims where interest was owed.

ELECTRONIC CLAIMS OVER 30 DAYS – NO INTEREST PAID

Population	Sample Size	Number of Claims Due Interest	Number of Exceptions	Error Rate
2104*	100	81	42	52%

{*5.21% of all electronic claims received}

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period, there were 2,554 paid and denied claims received in paper format.

Using ACL™ software, the examiners identified a population of 157 non-electronic claims paid, denied or settled in excess of forty-five (45) days during the period under examination. A random sample of 100 such claims was selected for review.

Upon review of the sample, the examiners determined that an interest payment was due in thirty-one (31) of the 100 claims reviewed. The Company was not in compliance with Colorado insurance law in that it failed to pay interest at a rate of ten percent (10%) annually of the total amount ultimately allowed on the claim to the insured or health care provider on twenty-four (24) of the thirty-one (31) clean, non-electronic claims that were not paid within forty-five (45) days of receipt and interest was owed.

NON-ELECTRONIC CLAIMS OVER 45 DAYS – NO INTEREST PAID

Population	Sample Size	Number of Claims Due Interest	Number of Exceptions	Error Rate
157*	100	31	24	77%

{*6.14% of all non-electronic claims received}

Denver Health provided documentation that of the 42,966 total claims received by the Company during the examination period. Using ACL™ software, the examiners identified a total population of fifty-eight (58) claims paid, denied or settled in excess of ninety (90) calendar days during the examination period.

The entire population of fifty-eight (58) claims was selected for review. The Company was not in compliance with Colorado insurance law in that it failed to pay a twenty percent (20%) penalty on the amount ultimately owed on all fifty-eight (58) claims that were not paid within ninety (90) days of receipt and a penalty was owed as required by Colorado insurance law.

CLAIMS OVER 90 DAYS – NO PENALTY PAID

Population	Sample Size	Number of Claims Due Penalty	Number of Exceptions	Error Rate
58*	58	58	58	100%

{*0.135% of all claims received}

Absent fraud, all claims are to be paid within ninety (90) days of receipt. Clean claims are to be paid within thirty (30) or forty-five (45) days of receipt, depending on the method of submission. Interest is owed on any clean claim which is not resolved within those time periods or on any unclean claim for which the carrier failed to take other the required action within the time periods. Required action includes allowing thirty (30) days after requesting the information for the provider to submit it before denying the claim.

If a clean claim remains unpaid ninety-one (91) days after receipt, both interest and penalty will be owed on the claim. Penalty is owed on a claim, clean or unclean, paid or denied, that is later adjusted and paid more than ninety (90) day after receipt, if the initial denial or need for a payment adjustment was due to an error of a carrier. In the instance of an additional payment on a claim, the penalty is paid only on the additional amount paid that is paid more than ninety (90) days after receipt.

Denver Health agreed with the findings of the previous market conduct examination and resulting Final Agency Order and stated its new system was correctly processing payment of penalty on all claims paid more than ninety (90) days after receipt. However, the results of this examination found no evidence that the Company was paying the required twenty percent (20%) penalty on claims paid, denied or settled over ninety (90) days as required by Colorado insurance law.

Recommendation No. 5:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its claims processing procedures regarding payment of interest and penalty for late payment of claims as set forth in Colorado insurance law.

In addition, in conjunction with Recommendation #3, Denver Health shall conduct a self-audit of all claims received July 1, 2011, through June 30, 2012, to determine the number of claims for which interest or penalty was owed but not paid or paid incorrectly. Denver Health shall pay the member or provider any interest or penalty which was owed but not paid. A report of the self-audit shall be provided to the Division no later than ninety (90) days from the date this report is adopted.

Utilization Review

Issue K1: Failure, in some instances, to make timely notification to covered persons of first level utilization review appeal determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to §§ 10-1-109, 10-3-1110, 10-16-109 and 10-16-113, subsections (2) and (3)(b), C.R.S., states in part:

. . .

Section 10 First Level Review

. . .

G. Notification Requirements

(1) *A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph (2) or (3).*

(2) With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, *but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review*.

(3) With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, *but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review*.

H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Section G., *the time period shall begin on the date the grievance requesting review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing*. [Emphases added.]

The examiners reviewed the entire population of ten (10) first level UR appeal files initiated by "covered persons" or their representatives during the examination period. All ten (10) first level appeal files reviewed were subject to the provisions of Section 10 of Colorado Insurance Regulation 4-2-17.

The Company was not in compliance with Colorado insurance law in that in three (3) out of the ten (10) first level appeal files reviewed, Denver Health failed to provide notification of the appeal decision to the covered person within the required time period of thirty (30) days.

FIRST LEVEL UR APPEALS – NOTIFICATION OF APPEAL DECISION

Population	Sample Size	Number of Exceptions	Error Rate
10	10	3	30%

In two (2) of the three (3) exceptions noted, the Company failed to date stamp the covered person's request for an appeal. In these instances, the examiners used the date the original request was dated. This had no effect on the number of first level appeal files noted to be out of compliance with Colorado insurance law.

Recommendation No. 6:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its utilization review procedures to ensure that all first level appeal decisions are communicated within the time period required by Colorado insurance law.

Issue K2: Failure to provide the name, title and qualifying credentials of the reviewer or clinical peer in first level utilization review determination notifications to covered persons.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to §§ 10-1-109, 10-3-1110, 10-16-109, and 10-16-113, subsections (2) and (3)(b), C.R.S., states in part:

> . . .
>
> Section 10 First Level Review
>
> . . .
>
> I. The decision issued pursuant to subsection G. shall set forth in a manner calculated to be understood by the covered person:
>
> 1. *The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults.* (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers".) [Emphasis added.]

The examiners reviewed the entire population of ten (10) first level UR appeal files initiated by "covered persons" or their representatives during the examination period. Each of the ten (10) first level appeal files reviewed was subject to the provisions of Section 10 of Regulation 4-2-17.

Denver Health was not in compliance with Colorado insurance law in that in all ten (10) of the first level appeal files reviewed, the Company's written communication of the appeal decision to the covered person failed to contain the name, title and qualifying credentials of the reviewer, or the qualifying credentials of the clinical peer in accordance with the provisions set forth in Colorado Insurance Regulation 4-2-17(10)(I)(1).

FIRST LEVEL UR APPEALS – NOTIFICATION OF REVIEWER/CLINICAL PEERS NAME, TITLE AND QUALIFYING CREDENTIALS

Population	Sample Size	Number of Exceptions	Error Rate
10	10	10	100%

Recommendation No. 7:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its utilization review appeal procedures to ensure that its first level utilization review appeal determination notifications contain all information required by Colorado insurance law.

Issue K3: Failure, in some instances, to provide a reference to the evidence or documentation used as the basis for an adverse first level utilization review determination in its notification to covered persons.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to §§ 10-1-109, 10-3-1110, 10-16-109, and 10-16-113, subsections (2) and (3)(b), C.R.S., states in part:

> . . .
>
> Section 10 First Level Review
>
> . . .
>
> I. The decision issued pursuant to subsection G. shall set forth in a manner calculated to be understood by the covered person:
>
> . . .
>
> 4. *A reference to the evidence or documentation used as the basis for the decision.* [Emphasis added.]

The examiners reviewed the entire population of ten (10) first level UR appeal files initiated by "covered persons" or their representatives during the examination period. Each of the ten (10) first level appeal files reviewed was subject to the provisions of Section 10 of Regulation 4-2-17.

Denver Health was not in compliance with Colorado insurance law in that in three (3) of the ten (10) first level appeal files reviewed, the Company failed to properly reference in its written communication the evidence or documentation used as the basis for making the determination as required by Colorado Insurance Regulation 4-2-17(10)(I)(4).

FIRST LEVEL UR APPEALS – NOTIFICATION OF EVIDENCE USED IN MAKING DECISION

Population	Sample Size	Number of Exceptions	Error Rate
10	10	3	30%

Recommendation No. 8:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its UR appeal procedures to ensure that its first level UR appeal determination notifications contain all information required by Colorado insurance law.

Issue K4: Failure, in some instances, to inform covered persons of their right to request and receive relevant information upon issuance of an adverse first level utilization review determination.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to §§ 10-1-109, 10-3-1110, 10-16-109, and 10-16-113, subsections (2) and (3)(b), C.R.S., states in part:

> . . .
>
> Section 10 First Level Review
>
> . . .
>
> J. A first level review decision involving an adverse determination issued pursuant to subsection G. shall include, in addition to the requirements of subsection I.:
>
> . . .
>
> 2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term relevant is defined in subsection F.2., to the covered person's benefit request.

The examiners reviewed the entire population of ten (10) first level UR appeal files initiated by "covered persons" or their representatives during the examination period. Each of the ten (10) first level appeal files reviewed was subject to the provisions of Section 10 of Regulation 4-2-17.

Denver Health was not in compliance with Colorado insurance law in that in three (3) of the ten (10) first level appeal files reviewed, the Company's written communication of the adverse appeal decision to the covered person failed to contain a statement of the covered person's right to receive, upon request and free of charge, all relevant documents, records and other information related to their benefit request in accordance with the provisions set forth in Colorado Insurance Regulation 4-2-17(10)(J)(2).

FIRST LEVEL UR APPEALS – NOTIFICATION OF RIGHT TO RECEIVE DOCUMENTATION

Population	Sample Size	Number of Exceptions	Error Rate
10	10	3	30%

Recommendation No. 9:

Denver Health shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17 during the examination period. In the event Denver Health is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Denver Health shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its utilization appeal procedures to ensure that its first level utilization review appeal determination notifications contain all information required by Colorado insurance law.

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Issue J1:	**Failure, in some instances, to allow the required time period for submission of needed additional information prior to denial of an unclean claim.** *(This is a repeat of issue J3 in the market conduct examination report as of December 31, 2006, signed August 28, 2008.)*	2	15
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State Market Conduct Examiners

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC

David M. Tucker, FLMI, ACS, AIE

And

Violetta R. Pinkerton, CIE, MCM, CPCU

Submit this report on this 15th Day of May, 2013 to:

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202